JOHNS HOPKINS
UNIVERSITY

Johns Hopkins Scleroderma Center
5501 Hopkins Bayview Circle, Room 1B7
Baltimore, MD 21224-6801
410-550-7715/FAX 410-550-1363

INTRODUCTION

The Johns Hopkins Scleroderma Center was established to provide care for patients with scleroderma and to conduct research to work towards new treatment. The Center provides **state-of-the-art medical care** through the care by scleroderma experts and by the medical faculty at Johns Hopkins University. The Center is also a place for teaching patients and physicians about scleroderma. It is a major Center in the United States that does both basic and clinical scleroderma research.

PHYSICIANS:

Fredrick M. Wigley, M.D.	***Special Interests:*** **Scleroderma and Raynaud's Phenomenon**
Laura K. Hummers, M.D.	***Special Interests:*** **Scleroderma and Scleromyxedema**
Francesco Boin, M.D.	***Special Interests:*** **Scleroderma and Fibrosing Skin Disorders**
Ami A. Shah, M.D., MHS	***Special Interests:*** **Scleroderma, Raynaud's Phenomenon, cancer in autoimmune diseases**

Each patient will be seen by one of the Scleroderma Center physicians. The Center has a number of other specialists in other fields with expertise in the problems that you may experience with scleroderma. Our clinical staff is available for patient problems, support, and education.

The Center is also very active in research. This research includes studies investigating the causes of scleroderma: 1) trials of new medications and treatments for scleroderma; 2) investigations into scleroderma lung disease; and 3) studies of the blood vessel disease of scleroderma and related Raynaud's phenomenon.

Today's Date _____

Dear _____:

You have been scheduled for an appointment in the Johns Hopkins Scleroderma Clinic:

Date: _____ Time: _____

LOCATION:

Johns Hopkins Asthma & Allergy Center ***(see enclosed map and directions)***
Division of Rheumatology, 1st Floor, Room 1B7
5501 Hopkins Bayview Circle
Baltimore, Maryland 21224-6801

PARKING:

Please park in the Mid-Campus Lot which is located across from the Johns Hopkins Asthma & Allergy Center ***(see attached map)***.

REGISTRATION:

Please arrive **30 minutes prior** to your appointment to accommodate parking, Johns Hopkins Security, and the pre-registration process.

WHAT TO BRING:

1. List of present medications
2. Medical Records from your doctor, if available ***(Medical Records Release Form enclosed)***
    - Particularly most recent labs, lung function tests, and ECHO of heart
3. Actual X-rays, CT scans, or other studies ordered by your doctor (if any)

EVALUATION – WHAT TO EXPECT:

You will be seen by a Scleroderma specialist, _____, and maybe by a physician-in-training. Please allow approximately **three hours** for your evaluation because tests might be scheduled.

INSURANCE:

We will bill your insurance company first; you are responsible only for amount not covered by your insurance. **Please bring all of the appropriate forms and insurance cards**.

FEE: The maximum fee for the initial visit is approximately **$576.00**. Co-payments are collected at the time of your visit. You may have additional fees for x-rays or laboratory studies. For your convenience, payments can be made with cash, Visa, MasterCard, travelers' checks, or personal checks. There is a parking fee (maximum $8.00 – cash only) charged by the Johns Hopkins Bayview Medical Institution.

CANCELLATION:

If you need any further assistance, or wish to cancel your appointment, please call **(410) 550-7715**. If you cannot make your appointment, please call within **48 hours** of your scheduled appointment.

We look forward to meeting you and providing the best possible care.

The Division of Rheumatology
5501 Hopkins Bayview Circle

OUTPATIENT REGISTRATION

PATIENT INFORMATION

Last _____ First _____ M.I. _____ Maiden _____

Sex _____ Marital Status _____ Race _____ DOB _____ SS# _____-____-_____

Address _____ Phone # _____

City _____ State ____ Zip _____ Emergency Contact (Name & Phone) _____

Employer _____ Employer Address _____ Phone _____

City _____ State _____ Zip _____

MEDICAL RECORD INFORMATION

Mother's Maiden Name _____ First Name _____

Father's Last Name _____ First Name _____

INSURANCE INFORMATION

Name _____ Policy # _____

Address _____ City _____ State/Zip _____

Phone # _____ Grp/Identification # _____ Effective Date _____

POLICY HOLDER INFORMATION

Is Patient the Policy Holder? (circle YES or NO). If NO, Guarantor Information needed.

Full Name _____ Address _____ Phone # _____

SS# _____-____-_____ Employer _____ Address _____

Employer Phone # _____

REFERRING PHYSICIAN

Name _____ Address _____ Phone # _____

Fax # _____ Specialty _____

PRIMARY CARE PHYSICIAN

Name _____ Address _____ Phone # _____ Fax # _____

AUTHORIZATION

In consideration of the treatment of the above patient, I/WE agree to pay the applicable charges and professional fees accrued and to pay the balance in full. I/WE assign insurance benefits and will submit necessary claim forms to cover the amount due. I/WE understand that I/WE have the responsibility for any unpaid amount.

Patient/Policy Holder Signature _____ Date _____

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MEDICAL RELEASE REQUEST

Date: _____

To: _____

_____

_____

Please release copies of all medical records, x-rays, CT's, and other pertinent information to:

- ☐ **Fredrick M. Wigley, M.D.**
- ☐ **Laura K. Hummers, M.D.**
- ☐ **Francesco Boin, M.D.**
- ☐ **Ami A. Shah, M.D., MHS**

  Johns Hopkins University
  Asthma & Allergy Center
  Rheumatology Department, 1st Floor
  5501 Hopkins Bayview Circle
  Baltimore, MD 21224-6801

If you have any questions regarding this request for information, please do not hesitate to call (410) 550-7715.

Sincerely,

_____
Patient Signature

_____
Print Name

_____
Address

_____
City, State, Zip

_____
Social Security Number

_____
Date of Birth

_____
Phone Number

Johns Hopkins Scleroderma Center
NEW PATIENT INFORMATION

WELCOME to the Scleroderma Center! Please fill out the following form to help us learn what brings you to our practice and how we can best help you.

Date of visit: _____

Your Name: _____

Address: _____

_____ _____
City **State** **Zip Code**

Telephone No.: (Home) _____ **(Work)** _____ **(Cell)** _____

Date of Birth: _____ _____ _____
Month **Day** **Year**

Gender: ☐ **Male** ☐ **Female**

Is your ethnicity Spanish/Hispanic/Latino?

☐ **No, not Spanish/Hispanic/Latino** ☐ **Yes, Spanish/Hispanic/Latino**

Race (Select all that apply):

☐ **White** ☐ **Black or African American** ☐ **Indian Sub-Continent**

☐ **Asian** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **Mid-East/Arabian**

☐ **American Indian/Alaska Native** ☐ **Other/Unknown**

Marital Status:

☐ **Single, never married** ☐ **Married** ☐ **Domestic Partnership** ☐ **Divorced**

☐ **Widowed** ☐ **Separated**

Education (Check highest level completed):

☐ **Grade School (up to grade 8)**

☐ **High School (received diploma/completed through grade 12)**

☐ **Tech/Trade School (completed a tech/trade school program)**

☐ **College (received college degree)**

☐ **Post-grad (completed post-graduate work)**

Scleroderma Center
NEW PATIENT INFORMATION
PAGE 2

Employment Status:

- ☐ **Currently employed**
- ☐ **Currently unemployed**
- ☐ **On disability**
- ☐ **Homemaker**
- ☐ **Retired**

Insurance (Please check one):

☐ **None** ☐ **Medical Assistance** ☐ **Private** ☐ **Self-pay** ☐ **Medicare**

Why have you come to the Johns Hopkins Scleroderma Center?

How long have you had this problem?

Please provide the name, address, phone number of the doctor who referred you and the name(s), addresses, and phone numbers of the doctors who should receive copies of your clinic notes, labs and test results. Clinic Notes and results will be sent to Primary Care Physician and/or Referring Physician ONLY. If the patient requests Clinic Notes and results be sent to any additional physician, there will be a $5.00 charge for each packet sent out.

PRIMARY CARE PHYSICIAN: _____
STREET ADDRESS: _____
CITY, STATE & ZIP CODE: _____
TELEPHONE #: _____ **FAX #:** _____

DOCTOR'S NAME: _____
STREET ADDRESS: _____
CITY, STATE & ZIP CODE: _____
TELEPHONE #: _____ **FAX #:** _____

DOCTOR'S NAME: _____
STREET ADDRESS: _____
CITY, STATE & ZIP CODE: _____
TELEPHONE #: _____ **FAX #:** _____

DOCTOR'S NAME: _____
STREET ADDRESS: _____
CITY, STATE & ZIP CODE: _____
TELEPHONE #: _____ **FAX #:** _____

Scleroderma Center
NEW PATIENT INFORMATION
PAGE 3

List your current medications (list everything including vitamins, aspirin, birth control pills, etc.)

	MEDICINE	**AMOUNT PER DAY**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

	NO	**YES**
Are you allergic to a medicine? **(If yes, name it: _____)**	____	____
Do you drink alcohol?	____	____
Do you currently smoke?	____	____
Are you a former smoker?	____	____

If YES to either question above, please answer:

- **a. Age first started smoking:** _____
- **b. Age stopped smoking:** _____
- **c. How many cigarettes do you currently smoke:** _____
- **d. How many cigarettes did you smoke in the past:** _____

Do you live with a smoker?	____	____
Do you work outside the home?	____	____
Do other people in your family have arthritis?	____	____
Have you had any major operations? **(If yes, name them:)** _____	____	____

_____

_____

Scleroderma Center
NEW PATIENT INFORMATION
PAGE 4

	NO	YES
Have you had any major illnesses (such as TB, hepatitis)?	____	____
(If yes, name them: _____)		

1. GENERAL HEALTH

a) Are you having fevers (temperature over 100 degrees)?	____	____
b) Do you have night sweats?	____	____
c) Have you lost more than 5 pounds in the last 3 months?	____	____
d) Do you have problems sleeping?	____	____

2. SKIN

a) Have you had any serious skin rashes?	____	____
b) Do you get rashes from the sun?	____	____
c) Have you had bumps or lumps in your skin?	____	____
d) Have you had psoriasis?	____	____
e) Is your hair falling out?	____	____

3. EYES

a) Have you lost your vision at any time?	____	____
b) Have you had a painful eye (iritis, uveitis)?	____	____
c) Have you had a red eye (conjunctivitis)?	____	____
d) Are your eyes very dry or gritty?	____	____

4. EARS

a) Have you had a swollen or painful outer ear?	____	____
b) Have you had frequent ear infections (otitis)?	____	____

5. NOSE

a) Have you had discharge or bleeding from the nose frequently?	____	____

6. MOUTH

a) Do you have frequent canker sores or mouth ulcers?	____	____
b) Do you have difficulty swallowing a cracker without water?	____	____
c) Have you had a yeast (thrush, candida) infection of the throat?	____	____

7. ENDOCRINE

a) Do you have swollen glands?	____	____
b) Do you have diabetes?	____	____
c) Do you have a thyroid problem?	____	____

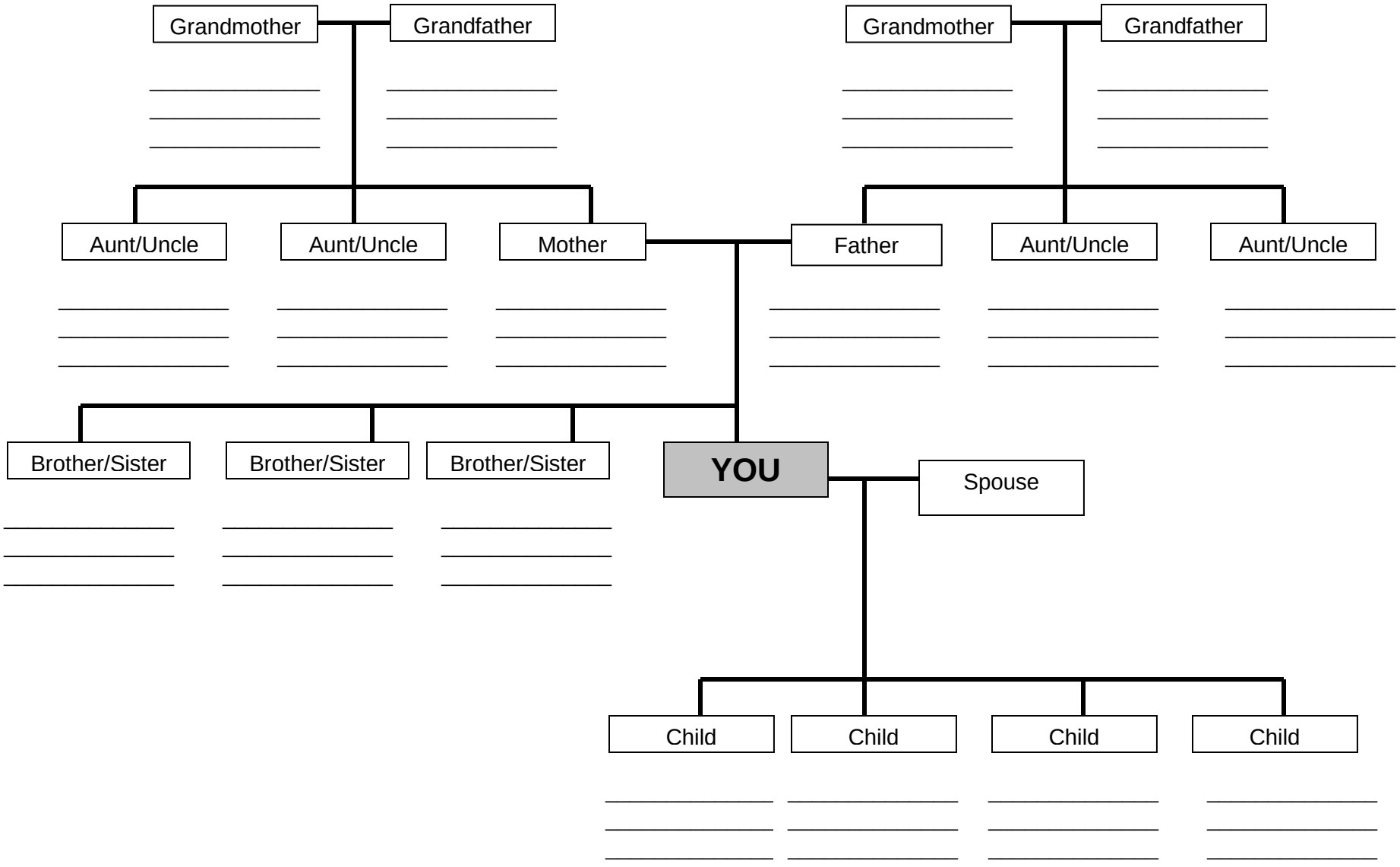
	NO	YES
8. CHEST		
a) Have you had pleurisy (a sharp pain when breathing)?	____	____
b) Have you had pneumonia?	____	____
c) Have you had fluid (water, effusion) in your lungs?	____	____
d) Are you short of breath easily?	____	____
9. CARDIAC		
a) Have you had inflammation of the heart lining (Pericarditis)?	____	____
b) Have you had a heart attack?	____	____
10. GASTROINTESTINAL		
a) Have you had difficulty swallowing or regurgitating?	____	____
b) Have you ever had stomach ulcers?	____	____
c) Have you had severe prolonged diarrhea?	____	____
d) Have you had blood in your stools frequently?	____	____
e) Do you have "irritable bowel" with diarrhea and constipation?	____	____
11. RENAL		
a) Have you had kidney failure?	____	____
b) Have you had blood in your urine?	____	____
c) Have you had a kidney stone?	____	____
12. GYN/GU		
a) (If a woman): Have you had any miscarriages?	____	____
b) (If a man): Have you had urethritis (painful urination)?	____	____
Have you had a problem with impotence?	____	____
13. EXTREMITIES		
a) Have you had any swelling (edema) of your feet or ankles?	____	____
b) Have you ever had blood clots (phlebitis)?	____	____
c) Do your fingers or toes turn color in the cold?	____	____
14. NEUROLOGIC		
a) Have you lost feeling anywhere on your body?	____	____
b) Do you have numbness or tingling in your hands?	____	____
c) Have you had a stroke (shock, paralysis)?	____	____
d) Do you have severe headaches?	____	____
e) Have you developed weakness anywhere in your body?	____	____

Family Medical History

Name: _____

☐ Please check here if you are one of twins

Date: _____



What is a Family Medical History?

What is a family medical history?

A family medical history is a record of illnesses among family members. As you can see, it is very much like a family tree. It depicts the relationship between each member of your family.

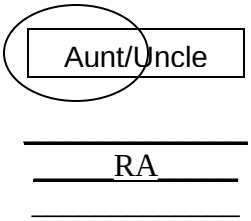
Why is a family medical history important?

By compiling a family medical history, it can help you and your doctors better understand your situation. It can help your doctors spot patterns of specific conditions and diseases among family members. Your family's medical history can be used for a number of things:

- Diagnosis of a medical condition
- Determining whether you are at high risk for developing certain diseases
- Determining if you may benefit from preventive measures to lower your risk of a specific disease

How to Complete the Family Medical History

The family medical history can be easily completed. From what you *KNOW* about your family, list the medical history under the corresponding family member's title. For example, if you would like to note that "Aunt Jane" had Rheumatoid Arthritis you would complete the form this way:



You would circle "aunt" and list her condition on the lines provided.

There are specific diseases and conditions that we are primarily interested in. If you *KNOW* that someone in your family history has been *diagnosed* with one of the conditions listed on the attached sheet, please list it.

Your Family History

Autoimmune Disorders

Addison's Disease	Hashimoto's Thyroiditis	Psoriatic Arthritis and Psoriasis
Alopecia Areata	Henoch-Schönlein Purpura	Raynaud's Phenomenon
Antiphospholipid Syndrome	Idiopathic Thrombocytopenic Purpura (ITP)	Reactive Arthritis (Reiter's Syndrome)
Ankylosing Spondylitis	IgA Nephropathy	Relapsing Polychondritis
Aplastic Anemia	Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)	Rheumatoid Arthritis
Autoimmune Hemolytic Anemia	Kawasaki's Disease	Sarcoidosis
Autoimmune Hepatitis	Lupus	Scleroderma
Behçet's	Multiple Sclerosis	Sjögren's Syndrome
Celiac Disease	Myasthenia Gravis	Still's Disease
Churg-Strauss Syndrome	Pemphigus and Bullous Pemphigoid	Takayasu's Arteritis
Cryoglobulinemia	Pernicious Anemia	Type 1 Diabetes Mellitus
Giant Cell Arteritis	Polyarteritis Nodosa	Uveitis
Goodpasture's Syndrome	Polymyalgia Rheumatica	Vasculitis
Grave's Disease	Polymyositis/ Dermatomyositis	Vitiligo
Guillain-Barré Syndrome	Primary Biliary Cirrhosis	Wegener's Granulomatosis

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

Travel Information

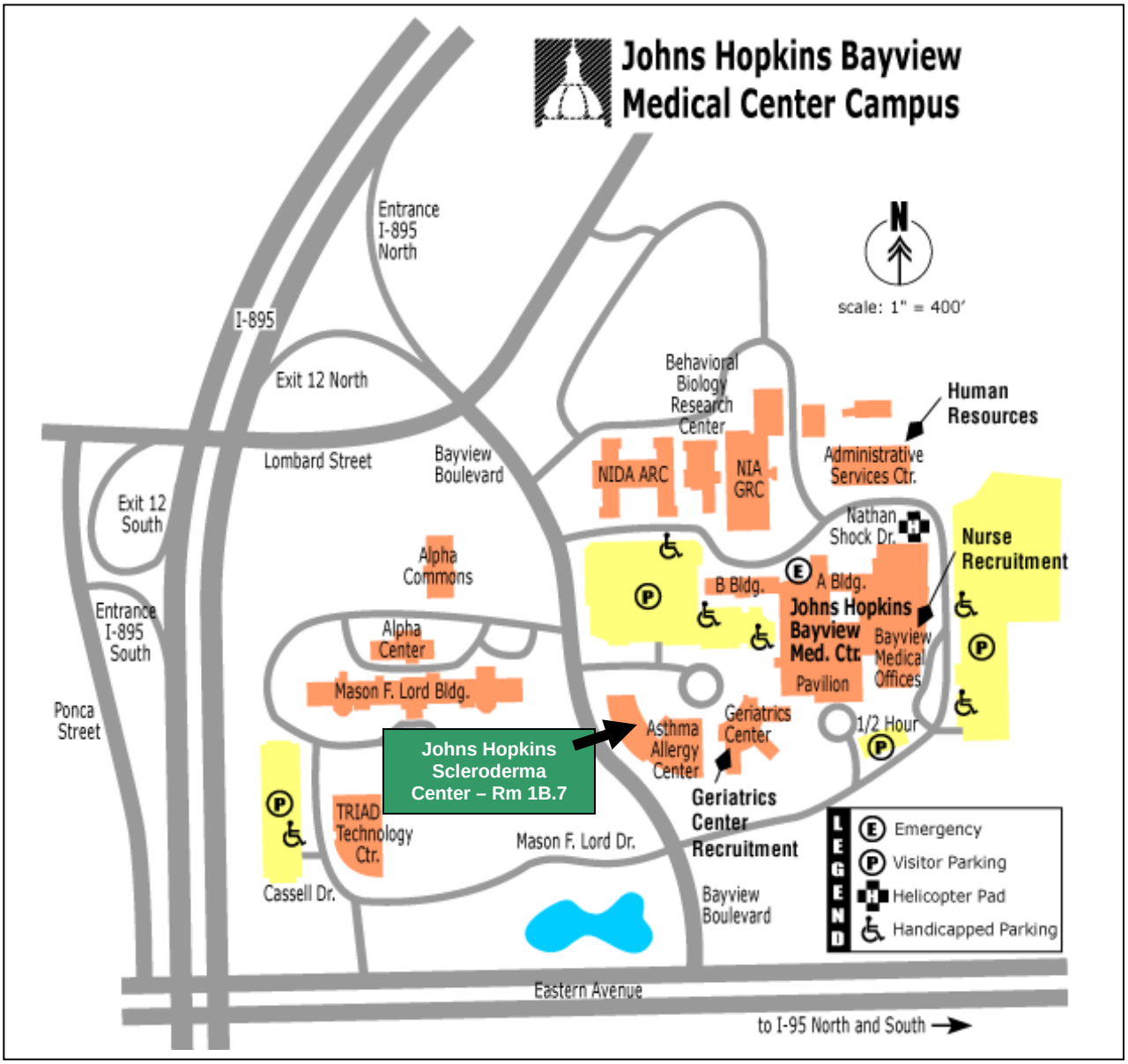
Direction Line Available
One phone call to 410–550–5748 provides patients or visitors with directions from the major interstates, and landmarks throughout the city.

A map of the Bayview campus is attached.

Directions:
From points South (including BWI Airport):
Take I-295 north to the Harbor Tunnel Thruway (I-895). After exiting the tunnel, take exit 12, Lombard Street. At the first stop light, proceed straight onto Bayview Boulevard.
or
Take I-95 through the Fort McHenry Tunnel to exit 59 (Eastern Avenue). Turn left onto Eastern Avenue and proceed approximately one mile to Bayview Boulevard on the right.

From points North and East:
Take I-95 south to exit 59 (Eastern Avenue). Turn right onto Eastern Avenue (west) and proceed approximately one mile to Bayview Boulevard on the right.
or
Take I-895 south to exit 12, Lombard Street. At the first stop light, turn right onto Bayview Boulevard.

JOHNS HOPKINS BAYVIEW MAP



Johns Hopkins Travel Department 800-225-2201
Hotels Near Baltimore's Inner Harbor

Admiral Fell Inn*
888 South Broadway
Baltimore, MD 21231
410-522-7377
410-522-0707 (fax)

Baltimore Marriott Inner Harbor
110 South Eutaw Street
Baltimore, MD 21201
410-962-0202, 1-800-228-9290
410-625-7892 (fax)

Biltmore Suites
205 W. Madison St.
Baltimore, MD 21201
410-728-6550 or 1-800-868-5064
410-728-5829 (fax)

Brookshire Suites*
120 E. Lombard Street
Baltimore, MD 21202
410-625-1300, 1-866-583-4162

Clarion Hotel Peabody Court
612 Cathedral Street
Baltimore, MD 21201
410-727-7101, 1-800-292-5500
410-789-3312 (fax)

Days Inn Baltimore Inner Harbor
100 Hopkins Place
Baltimore, MD 21201
410-576-1000, 1-800-329-7466
410-576-9437 (fax)

Harbor Court Hotel
550 Light St.
Baltimore, MD 21202
410-234-0550

Holiday Inn Inner Harbor
301 West Lombard Street
Baltimore, MD 21201
410-685-3500, 1-800-HOLIDAY
410-727-6169 (fax)

Hyatt Regency Baltimore
300 Light Street
Baltimore, MD 21202
410-528-1234, 1-800-233-1234
410-685-3362 (fax)

Inn at Henderson's Wharf**
1000 Fell St.
Baltimore, MD 21231
410-522-7777, 1-800-522-2088
410-522-7087 (fax)

Lancaster House (short-term rental property)
1611 Lancaster Street
Baltimore, MD 21231
443-996-4179

Mt. Vernon Hotel
24 W. Franklin Street
Baltimore, MD 21201
410-727-2000, 1-800-245-5256
410-576-9300 (fax)

Pier 5 Hotel*
(next to National Aquarium)
711 Eastern Avenue
Baltimore, Maryland 21202
410-539-2000, 877.207.9047

Radisson Plaza Lord Baltimore Hotel*
20-30 W Baltimore St.
Baltimore, MD 21201
410-539-8400

Renaissance Harborplace Hotel
202 E. Pratt St.
Baltimore, MD 21202
410-547-1200
410-539-5780 (fax)

Sheraton Inner Harbor Hotel
300 S. Charles St.
Baltimore, MD 21201
410-962-8300

Tremont Suite Hotels
222 Street Paul Place
Baltimore, MD 21202
410-727-2222
410-685-4215 (fax)

Wyndham Balto. Inner Harbor Hotel
101 W. Fayette St.
Baltimore, MD 21201
410-752-1100
410-752-0832 (fax)

* Take hotel shuttle to Main Hospital, then take Hopkins' shuttle van to Bayview
** Free taxi vouchers (requests only)